

AdVance™ Male Sling System



Frequently Asked Questions

1) What CPT® code is most commonly billed for a male urinary sling procedure that includes the use of the AdVance™ Male Sling System?

CPT 53440 (Sling operation for correction of male urinary incontinence) and **CPT 53442** (Removal or revision of sling for male urinary incontinence) are the most commonly billed codes when utilizing the AdVance Male Sling System.

2) Is prior authorization or pre-certification necessary for sling procedures?

As a rule, Medicare does not require prior authorization for any procedure. Commercial or private insurance carriers (e.g., Aetna, Blue Cross, etc.) and some Medicare Advantage Plans may require a prior authorization or precertification for surgical procedures. Therefore, it is recommended that you check with insurers (primary and secondary) to verify coverage and pre-certification requirements prior to performing any procedure.

3) CPT 53440 (Sling operation for correction of male urinary incontinence) and CPT 54405 (Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders and reservoir) may be performed during the same operative session. How is Medicare payment calculated for these multiple procedures?

Physician: When CPT 53440 and CPT 54405 are performed by the same physician during the same operative session, the multiple procedure rule will apply to the physician payment. This means the physician will be paid 100% of the Medicare payment for the first procedure and 50% of the Medicare payment rate for the second procedure.

Facility: In the case of the outpatient hospital reimbursement from Medicare, both CPT 53440 and CPT 54405 have an "S" status indicator. This indicator signifies "Significant Procedure, Not Subject to the Multiple Procedure Reduction," which means both procedures will be reimbursed at 100% of the payment rate.

4) Are AdVance™ Male Sling System procedures payable by Medicare in an Ambulatory Surgery Center (ASC)?

Yes, CPT 53440 is reimbursed by Medicare in the ASC setting.

5) What can be done if the patient is denied coverage by his health plan?

Patients should contact their insurance plan and request reconsideration. In addition, providers may appeal the denial and include a letter of medical necessity. Providers may contact the AMS Global Market Access Department at 888-865-3373 for information on appeal assistance.

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AMS does not promote the use of its products outside of the uses or indications as described in the applicable labeling.

Coding Resources:

1. CPT 2014. Current Procedural Terminology. Professional Edition. CPT is a trademark of the American Medical Association
2. HCPCS Level II Expert 2014. Ingenix, Inc. Salt Lake City, UT